Attachment A. III.
to Family Care Waiver
Application Pre-Print

Section A:
Program Impact

Marketing Review Tools

Program Impact: Marketing Review Tools

Standards for the CMO Member Handbook 2/2/00

CMO: _____

Date of receipt from CMO: _____

Date of response to CMO: _____

Folder & file: _____

The CMO member handbook must contain the following elements:

☐ Being a member of the CMO in Phase 3. This information shall include the nature of membership in a care management organization as compared to fee-for-service;

☐ Obtaining assistance for members with cognitive impairments to review materials about membership in the CMO;

☐ Location(s) of the CMO facility or facilities;

☐ Hours of service;

☐ Information on services in the LTC benefit package for Phase 3, including:
- ☐ list of services in the LTC benefit package (the list of the services appear on page 6 of this document);
- ☐ members' ability to select from the CMO's network of providers, and any restrictions on selecting providers in Phase 3;
- ☐ ability to change providers in Phase 3;
- ☐ any cost sharing related to these services;
  - which includes a note stating that the person loses eligibility if they fail to pay their cost share …

☐ Information on Medicaid covered services not in the LTC benefit package that remain fee for service and procedures for obtaining these services (for members who are Medicaid beneficiaries) for Phase 3, including:
- ☐ the list of these services (the list of the services appear on page 6 of this document);
  - how and where to obtain these services;
  - how transportation is provided;
  - any cost sharing related to these services;

☐ Provider network listing which includes:
- provider name (individual practitioner, or agency as appropriate);
- provider location, and telephone number;

- services furnished by the provider;
- whether the provider is accepting new CMO members or not;
- accessibility of the provider's premises (fi services rendered at provider's location)

[for Phase 3 member handbook only]

☐ The right to receive services from culturally competent providers and specific information about specific capacities of providers, such as languages spoken by staff etc.;

☐ Estate recovery: an explanation that such provisions extend to the CMOs

☐ Information on the extent to which members may obtain services outside of the provider network in Phase 3;

☐ Policies and procedures for advance authorization of services, and on the members' ability to obtain services necessary to achieve outcomes in Phases 3;

☐ Policies on use of after hours services;

☐ Policies on obtaining services out of the CMO's service area;

☐ Information on voluntary enrollment, voluntary disenrollment, and involuntary disenrollment in Phases 3;

☐ Procedure for members to have input on changes in the CMO's policies and services; and

☐ Notice of right to obtain information on results of member surveys. [draft BBA regs]

☐ Members' rights in Phase 3 as they appear below:

☐ To participate in planning and evaluating your services, including:
- Planning and evaluating your own treatment and services
- Choosing any other people you want to participate in planning your services
- Having service plan decisions arrived at using objective criteria

☐ To disenroll for any reason

☐ To choose from among services and providers, including:
- For "critical personal services," to choose any qualified provider who will accept the unit cost and meet other _____ CMO standards. "Critical personal services" are services that involve intimate personal needs or come into the home frequently.
- For other services, to choose from among the treatment professionals or providers within the CMO network, and to request additional providers to the network

- To have a member of your family paid, other than your spouse, to provide a service approved by the team if the family member who accept the unit cost and meets _____ CMO standards
- To choose providers outside the CMO network if it does not have providers with the specialized knowledge needed to treat your condition or meet your specific needs, such as your cultural needs
- To choose a self-directed care option

☐ To receive the services you need when you need them if you are eligible, including:
- An objective individualized assessment to determine your needs
- Development of an individual service plan tailored to meet your unique needs, circumstances and preferences as discovered through the assessment
- To receive services and supports from qualified providers that are prompt, adequate and appropriate for meeting your individual needs, and that as much as possible preserve your health, safety and well being, and keep you free from abuse and neglect

☐ To accuracy and privacy of, and to have access to, information about you

☐ To personal autonomy and other civil and legal rights, including being able to:

- Make your own choices and decisions to the extent that you are able, and to be supported in decision making in a manner that maximizes your ability and autonomy
- Manage and control your own services to the extent you are willing and able
- Receive treatment/services in the least restrictive conditions consistent with your service plan
- Live in the setting you choose unless there are essential health or long term support needs that cannot reasonably be met in such a setting, or the preferred setting includes a package of services that exceeds your identified needs.
- Develop an advance directive
- Fully exercise your rights as a CMO member and any other civil and legal rights to which you are entitled

☐ To dignity, respect, and fair and equitable treatment, and to be free from discrimination

☐ To assistance in understanding your rights and resolving complaints and grievances, including assistance from:
- Your team and other service providers
- A _____ CMO member advocate
- An external advocate not associated with _____ CMO or a provider

☐ To fair and equitable due process for resolving complaints and grievances, including:
- The opportunity to resolve complaints informally with the providers or team members

- Access to more formal processes for complaints and grievances, including the use of a process outside _____ CMO at any time
- Access to a State Fair Hearing, which may require you to first use a review from outside the _____ CMO depending on the situation
- Prompt resolution of any complaint you raise
- The right to bring a court action at any time against any organization, including the State, causing you damage from violating your rights
- To be guaranteed that the review of your services shall involve a professional having the training, credentials, and licensure required to provide treatment in the State, and having no financial interest in the decision
- To be represented by any advocate, peer or other representative you choose at any level of review and resolution of complaints or grievances, and to receive information about the availability of independent advocacy services, and other local consumer advocacy organizations and support groups that might assist you
- To be free from reprisal or the overt or implied threat of reprisal

☐ Members' responsibilities in Phase 3 as they appear below:

☐ To provide full, correct and truthful information requested by providers to determine eligibility, cost sharing, or to meet their reporting requirements

☐ To allow the release of records as needed

☐ To participate in the initial and ongoing development and implementation of your service plan

☐ To use any benefits you are entitled to under other programs or private insurance to pay for services before these expenses are charged to _____ CMO

☐ To use CMO providers unless you and your team mutually agree otherwise

☐ To accept services without regard for the provider's race, color, religion, age, gender, sexual orientation or national origin

☐ To pay the monthly cost-share that you are required to pay toward the services you receive

☐ To comply with emergency services procedures

☐ To participate in quality assurance processes

☐ To report in a timely manner any changes in your personal health, household or financial status which might affect eligibility or the amount of benefits or services received

- ☐ Information regarding complaints and grievances in Phase 3, which includes:
  - ☐ Specification of what constitutes grounds for a complaint, grievance, or a fair hearing request;
  - ☐ An explanation of how to file complaints, grievances and State fair hearing requests, which includes:
    - ☐ timeframes for doing so;
    - ☐ member's ability to appear in person before the CMO personnel assigned to resolve complaints and grievances
  - ☐ An explanation of the availability of assistance with the complaint and grievance process, and fair hearings;
  - ☐ Toll-free numbers that the member can use to register a complaint or submit a written grievance by telephone. The toll-free numbers must have adequate TTY and interpreter capability;
  - ☐ The specific titles and telephone numbers of the CMO staff who have responsibility for the proper functioning of the complaint and grievance process, and the authority to require corrective action;
  - ☐ Assurance that filing a complaint, grievance or requesting a State fair hearing process will not negatively affect or impact the way the CMO, its providers, or the Department treat the member; and
  - ☐ Information on how to obtain services during the grievance and fair hearing processes as specified in Article IV, I *Continuation of Benefits* (p. 33 of version 3, Dec 21, 1998 Health and Community Supports contract).

The list of services in the benefit package that are to appear in the member handbook:

- Adaptive Aids (general and vehicle) [1]
- Adult Day Care [1]
- Alcohol and Other Drug Abuse Day Treatment Services (in all settings) [2]
- Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis [2]
- Case Management (including Assessment and Case Planning) [1, 2]
- Communication Aids/Interpreter Services [1]
- Community Support Program [2]
- Counseling and Therapeutic Resources [1]
- Daily Living Skills Training [1]
- Day Services/Treatment [1]
- Durable Medical Equipment, except for hearing aids and prosthetics (in all settings)[2]
- Home Health [2]
- Home Modifications [1]
- Meals: home delivered [1] and congregate [3]
- Medical Supplies [2]
- Mental Health Day Treatment Services (in all settings) [2]
- Mental Health Services, except those provided by a physician or on an inpatient basis [2]
- Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease (IMD)[2]
- Nursing Services [2] (including respiratory care, intermittent and private duty nursing) and Nursing Services [1]
- Occupational Therapy (in all settings except for inpatient hospital) [2]
- Personal Care [2]
- Personal Emergency Response System Services [1]
- Physical Therapy (in all settings except for inpatient hospital) [2]
- Prevocational Services [1]
- Protective Payment/Guardianship Services [1]
- Residential Services: Residential Care Apartment Complex (RCAC) [1], Community Based Residential Facility (CBRF) [1], Adult Family Home [1]
- Respite Care (for care givers and members in non-institutional and institutional settings) [1]
- Specialized Medical Supplies [1]
- Speech and Language Pathology Services (in all settings except for inpatient hospital) [2]
- Supported Employment [1]
- Supportive Home Care [1]
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier[2]) and non-Medicaid covered [1]

footnote:

1 - Services with a suffix of "1" are Home and Community Based Waiver services
2 - Services with a suffix of "2" are Medicaid card services
3 - The service with a suffix of "3" is defined in the HSRS manual

The list of services that are excluded from the benefit package that are to appear in the member handbook:

- Alcohol and Other Drug Abuse Services provided by a physician or in an inpatient setting
- Audiology
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital: Inpatient and Outpatient, including emergency room care (except for Outpatient Physical Therapy, Occupational Therapy, Speech, Mental Health services from a non-physician, and Alcohol and Other Drug Abuse from a non-physician)
- Independent Nurse Practitioner Services
- Lab and X-Ray
- Medication
- Mental Health Services provided by a physician or in an inpatient setting
- Optometry
- Physician and Clinic Services (except for Outpatient Physical Therapy, Occupational Therapy, Speech, Mental Health services from a non-physician, and Alcohol and Other Drug Abuse from a non-physician)
- Podiatry
- Prenatal Care Coordination
- Prosthetics
- School Based Services
- Transportation: Ambulance

In addition to incorporating the elements of the member handbook, the following standards apply:

☐ All of the information in the member handbook regarding Phase 2 must be in accord with the requirements for a Phase 2 CMO

☐ All of the information in the member handbook regarding Phase 3 must be in accord the most recent version of the Health and Community Supports contract. The most recent draft of the contract is version 5 CMO.

☐ A statement from the CMO stating they have involved people in the target populations in the development of the member handbook

☐ The following are the parameters for the language and concepts in the member handbook:

- Practices that are discriminatory are prohibited.

- Practices that seek to influence enrollment in conjunction with the sale of any other insurance product are prohibited.

- Direct and indirect cold calls, either door-to-door or telephone are prohibited.

- Offer of material or financial gain to potential members as an inducement to enroll are prohibited.

- Information that could mislead, confuse or defraud consumers are prohibited.

- Information which is false is prohibited.

- Practices that are reasonably expected to have the effect of denying or discouraging enrollment are prohibited.

- Marketing/outreach activities that have not received written approval from the Department.

Phase 3 specifics for the member handbooks

☐ 1 phone number 24 hours / day

☐ Listing of provider network (specifics in the Health and Community Supports contract)

☐ Listing of independent advocate(s)
- Mentioning of the member's access to the Department's Independent Family Care Advocacy Entity

☐ Listing of TDY and toll free numbers

☐ Assurance from the CMO that the handbook was reviewed for input by people in the target population (specifics in the Health and Community Supports contract)

☐ If the handbook says that complaints and grievances are heard by a body other than the governing board, receive assurances from the CMO that that the board gave written approval for the transfer of that duty

☐ A statement saying the member can appear before the complaint and grievance body with their complaint or grievance (consider other specifics to describe how the member can grieve).

☐ Lay out the types of grievances which the member may take directly to the fair hearing process

☐ Revise right to add the underlined text: "… of your family paid, <u>other than your spouse</u>, to provide…"

☐ Clarify eligibility:
- criteria before 7/2000,

- criteria after 7/2000,

- eligibility of comprehensive LOC for "A" LTC benefit package,

- eligibility of intermediate LOC for "B" LTC benefit package

☐ Address (and phone) to use to file a complaint or grievance with the Department, and to file a grievance for a fair hearing process:

Department Complaints and Grievances
Address: c/o OSF Area Administration Section
P.O. Box 7850
Madison, Wisconsin 53707-7850
Toll-free: (888) 203-8338
Fax: (608) 266-8278
E-mail: famcare@dhfs.state.wi.us

State Fair Hearings
Address: DOA Division of Hearings and Appeals
5005 University Avenue, Room 201
Madison, WI 53705-5400
Phone: (608) 266-3096
Fax: (608) 264-9885

☐ Delete the word "State" from "State Fair Hearing"

☐ Slight changes of what's carved in and out (specifics in the Health and Community Supports contract version 5)

Phase 3 member handbooks should contain:

- Listing of the provider network.
  Contract Requirement: The CMO shall provide information on its provider network listing to members which includes:
  - provider name (individual practitioner, or agency as appropriate);
  - provider location, and telephone number;
  - services furnished by the provider;
  - whether the provider is accepting new CMO members or not; and
  - information on the extent to which members may obtain services outside of the provider network

- 1 phone number 24 hours / day.

- Listing of TDY and toll free numbers.

- Listing of independent advocate(s) available to assist members, including the Department's Independent Family Care Advocacy Entity.

- Assurance from the CMO that the handbook was reviewed for input by people in the target population (specifics in the Health and Community Supports contract).

- Update to eligibility criteria to state that non-MA people will not be enrolled prior to July, 2000.

- The following information about complaints and grievances:
  a) If the handbook says that complaints and grievances are heard by a body other than the governing board, the member must receive assurances from the CMO that the board gave written approval for the transfer of that duty;
  b) A statement saying members can appear before the complaint and grievance body with their complaint or grievance;
  c) A listing of the types of grievances which the member may take directly to the fair hearing process
  d) The address (and phone) to use to file a grievance with the Department and the fair hearing process;
  e) Delete the word "State" from "State Fair Hearing".

- Update wording to reflect waiver amendment allowing CMOs to pay for large CBRFs for elderly and people with physical disabilities, and to offer a private room option to members needing residential services. (See Program Transitions memo that is being sent with Home and Community Supports Contract).

Standards: Marketing Plan and Marketing Materials 12/9/99

CMO: _____

Date of receipt from CMO: _____

Date of response to CMO: _____

File & folder: _____

Preface

1. The CMO shall have a marketing plan approved by the Department.

2. The CMO engages only in marketing activities that have been approved by the Department, as follows.

3. Annually, the CMO shall submit a marketing plan to the Department and receive written approval before future HCS contracts.

4. The CMO shall submit to the Department for approval all marketing materials, including mailings sent only to members, prior to disseminating the materials.

5. The CMO agrees to comply with Ins. 6.07 and 3.27, Wis. Admin. Code.

6. The Department will review the marketing plan and materials as soon as possible, but within ten days of receipt. Marketing/outreach materials are deemed approved if there is no response from the Department within ten days. However, problems and errors subsequently identified by the Department must be corrected by the CMO when they are identified.

7. Approval of marketing plans and materials will be reviewed by the Department in a manner which does not unduly restrict or inhibit the CMO's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities.

Relevant definitions:

Marketing/Outreach Activities — the production and dissemination of marketing/outreach materials and the sponsorship of community events that can be reasonably interpreted as intended to influence individuals to enroll or reenroll in the CMO.

Marketing/Outreach Materials — materials in all mediums, including but not limited to, internet, brochures and leaflets, newspaper, magazine, radio, television, billboards, yellow pages, advertisements, other print media and presentation materials, used by or on behalf of the CMO to communicate with individuals who are not members, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the CMO.

Review of standards for: ☐ ***Marketing Plan*** ☐ ***Marketing Materials***

Marketing Plan	Marketing Materials	Provisions	Review Notes
		Practices that are discriminatory are prohibited.	
		Practices that seek to influence enrollment in conjunction with the sale of any other insurance product are prohibited.	
		Direct and indirect cold calls, either door-to-door or telephone are prohibited.	
		Offer of material or financial gain to potential members as an inducement to enroll are prohibited.	
		Activities and materials that could mislead, confuse or defraud consumers are prohibited.	
		Materials that contain false information are prohibited.	
		Practices that are reasonably expected to have the effect of denying or discouraging enrollment are prohibited.	
		Marketing/outreach activities that have not received written approval from the Department.	
		Marketing/outreach materials shall be distributed to all consumers eligible for the CMO in the service area.	

Note: Shaded box means the provision does not apply to the marketing plan or marketing material